DENTAL BULLETIN
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Missouri MEDICAID Bulletin

INDEX **PAGE**

MC+ HEALTH PLANS

MC+ Health Plans provide dental services as a benefit to their enrollees. Providers should contact the health plan for their program policies. The information contained in this bulletin refers to services provided on a fee-for-service basis.

DENTURES AND PARTIALS

Effective for dates of service on or after July 1, 1999, the dental program will allow immediate placement of dentures and partials following extractions. Providers should use procedure code D5130 when billing for the immediate placement of the maxillary denture and procedure code D5140 when billing for the immediate placement of the mandibular denture. The Medicaid Maximum Allowed for procedure code D5130 is $297.00 and the Medicaid Maximum Allowed for procedure code D5140 is $300.00. The 5% co-insurance applies to both codes.

PROCEDURE CODES D5110 AND D5120

Procedure codes D5110 (complete denture - maxillary) and D5120 (complete denture - mandibular) are to be used for replacement dentures or for recipients who have had teeth extracted waiting for full absorption prior to placement of dentures. This will be due either to the change in Medicaid's dental policy which allows for immediate dentures or because of client choice.

RELINES/REBASE

Effective for dates of service on or after July 1, 1999, one reline/rebase will be allowed during the 12 months following the placement of immediate dentures. The next reline is allowed 12 months following the first reline. A denture reline or rebase is not covered until 12 months after the placement of replacement dentures. Any additional denture relining or rebaseing is further limited to 3 years from the date of the last preceding reline or rebase.

PROCEDURE CODES D5211W5, D5212W5, D5630W5, AND D5660W5

Effective December 1, 1999, procedure codes D5211W5, D5212W5, D5630W5, and D5660W5 will no longer require the W5 modifier.

Following are the new descriptions for the listed procedure codes without the W5 modifier.

Procedure Code	New Description
D5211	Maxillary partial denture - acrylic base - with two bent-wire, cast gold or cast chrome clasps with rests (minimum three teeth excluding third molars)
D5212	Mandibular partial denture - acrylic base - with two bent-wire, cast gold or cast chrome clasps with rests (minimum three teeth excluding third molars)
D5630	Repair or replace broken clasp (bent wire, cast gold or cast chrome)
D5660	Add clasp to existing partial denture, maximum two clasps (bent wire, cast gold or cast chrome)

DENTAL HYGIENISTS

Effective July 1, 1999, the Missouri Medicaid policy for the supervision of dental hygienists is consistent with guidelines established by the Missouri Dental Board in State regulation 4 CSR 110-2.130.

DENTAL CERTIFICATION FORM

Effective immediately the Dental Certification From is no longer required. Procedure codes which previously required prior authorization (PA) will continue to require the PA, however the Dental Certification Form is not required when submitting a PA or when submitting a claim.

POSTOPERATIVE CARE

Postoperative care includes 30 days of routine follow-up care for those surgical or diagnostic procedures having a Medicaid reimbursement amount of $75.00 or more. The postoperative care policy also applies to the "Office Surgical Procedures" with the W1 modifier. For counting purposes, the date of surgery is the first day. This policy applies whether the procedure was performed in the hospital, an ambulatory surgical center, or an office setting, and applies to subsequent physician visits in any setting (e.g., inpatient and outpatient hospital, office, home,

nursing home, etc.). Pain management is considered part of postoperative care. Visits for the purpose of postoperative pain control are not separately reimbursable.

Follow-up care provided by the assistant dental surgeon is subject to the 30-day postoperative policy. Supplies necessary for providing the follow-up care in the office, such as surgical dressings in connection with covered surgical procedures that are subject to the postoperative care policy, may be billed under procedure code D9999. When using procedure D9999 for supplies provided during the postoperative period, an invoice of cost for the supplies used and a written description of the supply(s) must be included with the claim form.

DENTAL X-RAYS AND ORTHODONTIC PHOTOGRAPHS

Providers must identify x-rays and photographs with the provider's name and Medicaid provider number when sending dental x-ray(s), photographs or both along with claims or prior authorization requests to GTE Data Services. This can be accomplished by putting the provider's name and number on the x-ray (if large enough), or on the back of photographs. When properly marked, GTE Data Services will know to whom the items are to be returned if separated from the claim or prior authorization request.

RATE INCREASES FOR STATE FISCAL YEAR 2000

The 90th Missouri General Assembly approved an appropriation to increase rates for certain dental services. The procedure codes and the new reimbursement rates are listed on pages 5 - 8 of this bulletin.

All of the rate increases are effective for dates of service on and after July 1, 1999. Claims that adjudicate prior to the completion of the system updates will be mass adjusted by the Division of Medical Services on a future remittance advice. Providers will be reimbursed the lower of their billed charge or the Medicaid Maximum Allowable.

An appropriation was also approved to increase rates in the Physician Program for dates of service on or after July 1, 1999. The appropriation was used to increase Medicaid reimbursement for certain surgical procedures. In compliance with the Omnibus Reconciliation Act (OBRA) of 1997 requiring states to recognize certain medical and surgical procedures performed by dentists as physician services, dental providers will receive the same fee increase as physicians for those covered Physicians' Current Procedural (CPT) codes that qualify as physician or dental services. CPT procedure codes and the new Medicaid Maximum Allowed are listed on page 8 of this bulletin.

BILLING REMINDER

When billing Missouri Medicaid for services furnished to recipients, providers should always bill Medicaid using their usual and customary charge(s) to the general public for the service(s) being provided. Billing or coding of services which results in payments in excess of the provider's charges to the general public for the same service is a Medicaid Program Violation (13 CSR 70-3.030(2)2).

NEW DENTAL CLAIM FORM

Effective immediately the Missouri Medicaid program will have available and will accept the new American Dental Association (ADA) 1999 version 2000 claim form for the filing of dental claims. The Missouri Medicaid program will accept dental claims submitted on either the Medicaid dental claim form or the new ADA claim form through April 30, 2000. Only the ADA 1999 version 2000 claim form will be accepted for dental claims received on and after May 1, 2000. Claim filing instructions for the new ADA claim form and an example of a completed claim form are included with this bulletin. The old Missouri Medicaid dental claim form may be ordered until January 31, 2000.

The new ADA 1999 version 2000 claim form will be available for providers on November 1, 1999. Providers must specify which dental claim form is being ordered. Providers may order both claim forms by calling the Provider Relations Unit at 1-800-392-0938 or 573-751-2896. A blank ADA 1999 version 2000 claim form is attached to this bulletin and may be photo copied.

DENTAL FEE INCREASE SCHEDULE

The Medicaid Maximum Allowed do not include any cost sharing or co-insurance amounts.

Procedure Code	Description of Procedure	Medicaid Maximum Allowed 07/01/99
	ENDODONTICS	
D3310	Root Canal - anterior	$ 97.00
D3320	Root Canal - bicuspid	$118.00

Procedure Code	Description of Procedure	Medicaid Maximum Allowed 07/01/99
D3330	Root canal - molar	$155.00
	PROSTHODONTICS, REMOVABLE	
D5110	Dentures-acrylic only-complete upper	$297.00
D5120	Dentures-acrylic only-complete lower	$300.00
D5211	Upper partial-acrylic base w/bent wire, cast gold or cast chrome clasps & rests	$224.00
D5212	Lower partial-acrylic base w/bent wire, cast gold or cast chrome clasps & rests	$225.00
D5410	Adjust complete denture-maxillary	$ 13.00
D5411	Adjust complete denture-mandibular	$ 13.00
D5421	Adjust partial denture-maxillary	$ 13.00
D5422	Adjust partial denture- mandibular	$ 13.00
D5510	Repair broken complete denture base	$ 33.00
D5520	Replace missing or broken teeth-complete denture (each tooth)	$ 26.00
D5610	Repair resin denture base	$ 32.00
D5630	Repair or replace broken clasp-bent wire, cast gold, cast chrome	$ 51.00
D5640	Replace broken teeth-per tooth	$ 25.00
D5650	Add tooth to existing partial denture	$ 34.00
D5660	Add clasp to existing partial denture-bent wire, cast gold, cast chrome	$ 49.00
D5710	Rebase complete maxillary denture	$107.00
D5711	Rebase complete mandibular denture	$106.00
D5720	Rebase maxillary partial denture	$104.00

Procedure Code	Description of Procedure	Medicaid Maximum Allowed 07/01/99
D5721	Rebase mandibular partial denture	$105.00
D5730	Reline complete maxillary denture-chairside	$ 56.00
D5731	Reline complete mandibular denture-chairside	$ 56.00
D5740	Reline maxillary partial denture-chairside	$ 53.00
D5741	Reline mandibular partial denture-chairside	$ 53.00
D5750	Reline complete maxillary denture-laboratory	$ 85.00
D5751	Reline complete mandibular denture-laboratory	$ 85.00
D5760	Reline maxillary partial denture-laboratory	$ 80.00
D5761	Reline mandibular partial denture-laboratory	$ 80.00
D5820	Interim partial-maxillary w/o clasps-acrylic-one tooth	$125.00
D5820W5	Interim partial-maxillary w/o clasps-acrylic-two teeth	$125.00
D5820W6	Interim partial-maxillary w/o clasps-acrylic-three teeth	$127.00
D5820W9	Interim partial-maxillary w/o clasps-acrylic-four teeth max	$141.00
D5821	Interim partial-mandibular w/o clasps-acrylic-one tooth	$130.00
D5821W5	Interim partial-mandibular w/o clasps-acrylic-two teeth	$125.00
D5821W6	Interim partial-mandibular w/o clasps-acrylic-three teeth	$127.00
D5821W9	Interim partial-mandibular w/o clasps-acrylic-four teeth max	$141.00
D5850	Tissue conditioning-maxillary-per denture unit	$ 34.00
D5851	Tissue conditioning-mandibular-per denture unit	$ 35.00
	ORAL SURGERY	
D7110	Extractions - single tooth-deciduous	$ 13.00

Procedure Code	Description of Procedure	Medicaid Maximum Allowed 07/01/99
D7110W5	Extractions - single tooth-permanent	$ 19.00
D7120	Each additional tooth - deciduous	$ 11.00
D7120W5	Each additional tooth - permanent	$ 13.00
	ADJUNCTIVE GENERAL SERVICES	
D9240	IV Sedation	$ 55.00

CPT FEE INCREASE SCHEDULE

Procedure Code	Description of Procedure	Medicaid Maximum Allowed 07/01/99
13152	Repair, complex, eyelids, nose, ears, and/or lips; 2.6 cm to 7.5 cm	$155.00
20005	Incision of soft tissue abscess (Eg. secondary to osteomyslitis; deep or complicated	$ 71.00
21365	Open treatment of complicated (Eg. comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	$369.00
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation interdental fixation, and/or wiring of dentures or splints	$431.00

ADA 1999 VERSION 2000 CLAIM FILING INSTRUCTIONS

NOTE: An asterisk (*) beside a field number indicates a required field. This field ***must*** be completed or the claim will be denied. The double asterisks (**) beside a field number indicates this field is required only in specific situations. All other fields should only be completed when applicable.

FIELD NAME & NUMBER	INSTRUCTIONS
1. -7	Not required.
* 8. Recipient Name	Enter the recipient's last name first, first name, and middle initial as shown on the recipient's Medicaid card.
9. Recipient Address	Enter the recipient's street address.
10. City	Enter the recipient's city of residence.
11. State	Enter the recipient's state of residence.
12. Recipient Birth Date	Enter the recipient's date of birth in month/day/year numeric format.
*13. Patient ID#	Enter the Medicaid ID number exactly as shown on the recipient's Missouri Medicaid card.
14. Sex	Check the appropriate box.
15. Phone Number	Enter the recipient's phone number, if available.
16. Zip Code	Enter the recipient's zip code.
17. -18	Not required.
**19-30. insurance coverage.	When verifying the recipient's eligibility, verify if there is other If applicable, enter the name of the dental insurance, their address, and the policy number. If the other insurance pays, the amount paid should be entered in Field 59, section "Payment By Other Plan". **LEAVE BLANK IF THERE IS NO OTHER DENTAL COVERAGE.** (These fields should reflect only non-Medicaid/Medicare information.)

****31-37. Other Insurance	Required only if recipient has a second dental policy. **LEAVE BLANK IF THERE IS NO OTHER DENTAL COVERAGE.** (This field should reflect only non-Medicaid information.)
38. -41	Not required.
*42. Dentist Name	Write or type the provider's name exactly as it appears on the label.
43. Phone Number	Write or type the provider's phone number.
***44. Provider ID #	Write or type the provider's Missouri Medicaid provider number exactly as it appears on the provider label.
45. Dentist Soc. Sec. or T.I.N.	Write or type the dentist's Social Security or Tax Identification Number.
46. Address	Write or type the provider's street address.
47. Dentist License #	Write or type the provider's Missouri dental license number.
48. First Visit Date	List the date of the first visit in the current series of treatment.
49. Place of Treatment	Not required.
50. City	Write or type the city where the provider is located.
51. State	Write or type the state where the provider is located.
52. Zip Code	Write or type the appropriate zip code.

Fields 42, 46, 50, 51 and 52 may be completed with the use of the Missouri Medicaid provider label.

**53. Radiographs Enclosed	Mark "yes" if x-rays accompany the claim. ***Do not*** send x-rays routinely. The State Consultant will request x-rays if needed. X-rays are required for the final quarterly payment for orthodontic services and when billing procedure code D7250.
54. Is Treatment for Orthodontics?	Not required.
**55. If Prosthesis, is This Initial Placement?	Mark the appropriate box. If "no", state payment source and date of placement. If this information is not available, enter "unknown"

	in this field. **This field is required when billing for full or partial dentures.**
*56. Is Treatment a Result Of ...	If treatment is the result of an occupational illness or injury, mark "yes" and list the date, location, and cause, otherwise, mark "no".
*57. Is Treatment a Result Of ...	Mark the appropriate box. If marked "yes", enter date and location.
58. Diagnosis Code Index	Not required.
*59. Date of Service Performed	Enter the actual date services were rendered in month/day/year numeric format. **REMINDER: The date of service for dentures(full or partial) is the date of placement.**
* Tooth Number or Letter	Enter the appropriate tooth number or letter for services performed on each line item of the claim. If a particular tooth number or letter does not apply, use tooth number 33 (all teeth). When billing for partial dentures enter the tooth number for one of the teeth being replaced in this field, then list the remaining teeth in the description field. Alveoplasties should be billed using tooth number 1 for upper right quadrant, 9 for upper left quadrant, 17 for lower left quadrant, and 25 for lower right quadrant.
* Surface Code	Complete this field, **if applicable**.

Diagnosis Index # Not Required.

* Procedure Code	Enter the five digit code for the service performed, as well as any applicable modifiers.
* Quantity	The quantity will always be one (1) except for some injection codes.
** Description	Only required in specific situations as indicated in the Dental Manual.
* Fee	Enter the your usual and customary fee for the procedure(s) performed.
* Total fee	Enter the total of the charges shown.

** Payment by Other Plan	Enter the total amount received by all other insurance resources. Previous Medicaid payments, and cost sharing co-insurance or copay amounts are not to be entered in this field. If the other insurance denied the claim, attach a copy of the Explanation of Benefits which denied the charges.
* Admin. Use Only	You may enter the recipient's patient account number in this field.
Maximum allowable	Not required.
Deductible	Not required.
Carrier %	Not required.
Carrier paid	Not required.
Patient pays	Not required.

Reminder: Each procedure code must be billed on a separate line, except that when billing code 41899 for General Relief and adults with ME codes 76, 77, 78, and 79 the provider must list each supporting dental code that was performed.

60. Identify the missing teeth...	Not required.
**61. Remarks	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
62. -66	Not required.